705 Summerfield Avenue, Asbury Park, NJ 07712 • Phone: (732) 774-6886 • FAX: 732-774-8809

REGISTRATION/INSURANCE FORM

Today's Date: ___________________________ Therapist's Name: ___________________________________

Legal Name: _____________________________________ Other Name: ______________________________

Home Address: ____

Cell Phone: (_____) ____________________ Other Phone: (_____) ___________________

Date of Birth: _____/_____/_____ SS# ______-______-_______

Legal Gender (circle one): Male / Female / Unknown

Gender Identity (circle one): Prefer not to answer/ Undefined/ Male/ Female/ Transgender M-F/ Transgender F-M/ Non-binary/ Other

Race: _________________ **Ethnicity (circle one):** Hispanic-Latino / Non-Hispanic-Latino

Marital Status (circle one): Single/ Married/ Civil Union / Divorced/ Widowed / Domestic Partner

EMERGENCY CONTACT: ________________________________ Contact Phone: (_____) _________________

Your Occupation: _____________________ Name of Employer: _____________________________________

Employer Address: ____

Can we contact you at work? Yes / No Work Phone: (_____) ___________________ ext. ___________

☐ I do not have insurance

☐ I choose to self-pay all fees for all services

Insurance Information:

Name of Policy Holder: ________________________________ Relationship: __________________________

Policy Holder's Date of Birth: ______/______/______ Policy Holder's SS #: ____________________________

Primary Insurance: ____ ID#: ________________________

Group#: ________________________ Phone number for Providers: _________________________________

Secondary Insurance: ____ ID#: _________________________

Group#: ________________________ Phone number for Providers: _________________________________

I hereby authorize you to provide a copy of and/or disclose information related to my medical records or other information regarding me in your possession, to my insurance carrier(s) or other authorized third-party payer(s) and their review organization(s), as needed, for purposes of determining my benefits for services, for filing claims, for obtaining payment for services, and for other purposes, as allowed by law.

Signature: ____ **Date:** _______________________

JFCS Quality of Life for All

Legal Information

for Psychiatric Advance Directive, Living Will, and Durable Power of Attorney

Do you have a Psychiatric (Mental Health) Advance Directive?

☐ Yes ☐ No

If yes, is it on file with the State of New Jersey?

☐ Yes ☐ No

If yes, please provide: Registrant ID Number: ______________________

If no, are you interested in receiving more information about a Psychiatric Advance Directive?

☐ Yes ☐ No

Do you have a Living Will?

☐ Yes ☐ No

Name of Health Care Proxy: ____________________________________

Address of Health Care Proxy: ____

Phone # of Health Care Proxy: ______________________

Do you have Durable Power of Attorney (DPOA)?

☐ Yes ☐ No

If yes, please provide:

Is your DPOA On File?

☐ Yes ☐ No

Name of DPOA: ____________________________________

Address of DPOA: ____

Phone # of DPOA: ________________________

I attest that the information above is correct.

Client Name: ______________________________________

Client Signature: ____________________________________ **Date:** __________________

Jewish Family and Children's Service of Monmouth County
705 Summerfield Avenue, Asbury Park, NJ 07712 • Phone: (732) 774-6886

COPIES OF COMPLETE PRIVACY NOTICE AVAILABLE AT RECEPTION DESK

F. <u>NOTICE OF PRIVACY PRACTICES (SHORT VERSION)</u>

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our commitment to your privacy

Jewish Family and Children's Service of Greater Monmouth County is dedicated to maintaining the privacy of your personal health information. We are required also by law to do this. These laws are complicated, but we must provide you with important information. This notice is a shorter version of the full, legally required NPP which is available to you upon request. However, we can't cover all possible situations so please talk to our Privacy Officer (see the end of this notice) about any questions or problems.

We will use the information about your health which we get from you or from others mainly to provide you with treatment, to arrange payment for our services or for some other business activities which are called, in the law, health care operations. After you have read this NPP we will ask you to sign a Consent Form to let us use and share your information. If you do not consent and sign this form, we cannot treat you.

If we or you want to use or disclose (send, share, release) your information for any other purposes we will discuss this with you and ask you to sign an Authorization to allow this.

Of course, we will keep your health information private but there are some times when the laws require us to use or share it such as:

1. When there is a serious threat to your health and safety or the health and safety of anther individual or the public. We will only share information with a person or organization who is able to help prevent or reduce the threat.
2. Some lawsuits and legal or court proceedings.
3. If a law enforcement official requires to do so.
4. For Workers Compensation and similar benefit programs.
5. A bill may be sent to you or any private or public source of health coverage you have identified. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, treatment, and services provided. We may also tell your health plan about a treatment you are going to receive to obtain prior approval, or to determine whether your plan will cover the treatment.

Quality of
Life for All

Your rights regarding your health information

1. You can ask us to communicate with you about your health and related issues in a particular way or at a certain place. For example, you can ask us to call you at home, and not at work to schedule or cancel an appointment. We will try our best to do as you ask.
2. You have the right to ask us to limit what we tell certain individuals involved in your care or the payment for your care, such as family members and friends. While we don't have to agree to your request, if we do agree, we will keep our agreement except if it is against the law, or in an emergency, or when the information is necessary to treat you.
3. You have the right to look at the health information we have about you such as your medical and billing records, and psychotherapy notes. You can even get a copy of these records but we may charge you. Contact our Privacy Officer to arrange how to see your records.
4. If you believe the information in your records is incorrect or incomplete, you can ask us to make some kinds of changes (called amending) to your health information. You have to make this request in writing and send it to our Privacy Officer. You must tell us the reasons you want to make the changes.
5. You have the right to a copy of this notice. If we change this NPP we will post it in our waiting room and you can always get a copy of the NPP from the Privacy Officer.
6. You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with our Privacy Officer and with the Secretary of the Department of Health and Human Services. All complaints must be in writing. Filing a complaint will not change the health care we provide to you in any way.

If you have any questions regarding this notice or our health information privacy policies, please contact our Privacy Officer, who is Wendy Zagha, Director of Clinical Services, and can be reached by phone at (732) 774-6886 or by e-mail at Wendyz@jfcsmonmouth.org

The updated effective date of this notice is 9/1/2020.

E. <u>CONSENT FORM FOR THE USE AND DISCLOSURE OF PHI</u>
<u>CLIENT COMPLAINT PR0CEDURE AND CONSUMER RIGHTS</u>

CONSENT TO THE USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS.

I, ______________________________ , understand and agree that Jewish Family and Children's Service of Greater Monmouth County may use and disclose protected health information (including but limited to name, address, health history, symptoms, examination and test results, diagnosis and treatment) for treatment, payment or health care operations. I understand that I must consent to this use and disclosure in order to enroll in or receive services through the Jewish Family and Children's Service.

I understand and have been provided with a copy of the document entitled Notice of Privacy Practices that provides a complete description of potential uses and disclosures of my protected health information. I understand that I have the right to review the Notice of Privacy Practices prior to signing the consent.

I understand that JF&CS reserves the right to change its privacy practices and will provide a copy of any materially revised notice at my next appointment or will mail one to me upon my request to the address that I have provided. Copies will also be available in the office waiting rooms.

I understand that I have the right to request how protected health information is used or disclosed to carry out treatment, payment or health care operations. I further understand that JF&CS is not required to grant any request to restrict the use or disclosure of information. If, however, the JF&CS agrees to the requested restriction, the restriction is binding on JF&CS.

I agree that I have the right to revoke this Consent in writing, except to the extent JF&CS, has already relied upon it. I understand that if I do revoke this consent, JF&CS may choose to discontinue providing me with healthcare treatment and services.

______________________________________ ______________________
Client, or Personal Representative Signature Date

______________________________________ ______________________
Witness, Title Date

I have received a written copy of the Client Complaint Procedure and Consumer Rights, and the Cancellation Policy. They have been explained and I understand all documents.

______________________________________ ______________________
Client, or Personal Representative Signature Date

______________________________________ ______________________
Witness, Title Date

Jewish Family & Children's Service of Monmouth County
Quality of Life for All

Telemental Health Informed Consent

I ______________________________________, (name of client) hereby consent to participate in telemental health with ____________________ (name of provider) as part of my psychotherapy. I understand that telemental health is the practice of delivering clinical health care services via technology assisted media or other electronic means between a practitioner and a client who are located in two different locations.

I understand the following with respect to telemental health:

1. I understand that I have the right to withdraw consent at any time without affecting my right to future care, services, or program benefits to which I would otherwise be entitled.
2. I understand that there are risk and consequences associated with telemental health, including but not limited to, disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.
3. I understand that there will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law.
4. I understand that the privacy laws that protect the confidentiality of my protected health information (PHI) also apply to telemental health unless an exception to confidentiality applies (i.e. mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others; I raise mental/emotional health as an issue in a legal proceeding).
5. I understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that telemental health services are not appropriate and a higher level of care is required.
6. I understand that during a telemental health session, we could encounter technical difficulties resulting in service interruptions. If this occurs, end and restart the session. If we are unable to reconnect within ten minutes, please call me at _____________ to discuss since we may have to re-schedule.

7. I understand that my therapist may need to contact my emergency contact and/or appropriate authorities in case of an emergency.

Emergency Protocols

I need to know your location in case of an emergency. You agree to inform me of the address where you are at the beginning of each session. I also need a contact person who I may contact on your behalf in a life- threatening emergency only. This person will only be contacted to go to your location or take you to the hospital in the event of an emergency.

In case of an emergency, my location is: ____ and

my emergency contact person's name, address, phone: __________________________________

____

I have read the information provided above and discussed it with my therapist. I understand the information contained in this form and all of my questions have been answered to my satisfaction.

____ ______________________

Signature of client/parent/legal guardian Date

____ ______________________

Signature of therapist Date

The information is provided as a service to members and the social work community for educational and information purposes only and does not constitute legal advice. We provide timely information, but we make no claims, promises or guarantees about the accuracy, completeness, or adequacy of the information contained in or linked to this Web site and its associated sites. Transmission of the information is not intended to create, and receipt does not constitute, a lawyer-client relationship between NASW, LDF, or the author(s) and you. NASW members and online readers should not act based on the information provided in the LDF Web site. Laws and court interpretations change frequently. Legal advice must be tailored to the specific facts and circumstances of a particular case. ***Nothing reported herein should be used as a substitute for the advice of competent counsel.***

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Quality of
Life for All

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Leslie Kornfeld

Director of Operations
Gail Zapata

Clinical Director, Mental Health
Wendy Zagha, LCSW

Clinical Director, Recovery Services
Hilary Krosney-Rediker, LPC, LCADC

Director of Licensing & Holocaust
Survivor Services
Jenifer Zylstra, LSW

Medical Director
Dr. David E. Wolff, M.D., M.P.H.

EMAIL AND TEXT MESSAGE ACCOUNT ALERTS

Jewish Family & Children's Service now has the ability to email arid/or text you, reminding you of your appointments. If you would like to receive this feature in the future, please read the consent below and sign.

I authorize Jewish Family & Children's Service to send email and/or text message appointment reminders to me on my provided email and cell phone number. I understand that I may reply with various commands to confirm or cancel an appointment. By accepting these terms, I agree that all individuals associated with my account may receive alerts referencing your appointment. Text message charges from my cell phone provider may apply and I understand that I am responsible for these fees.

Client Name: ____

_____ (Client Initials) I consent to receive **text messages** from JFCS on my cell phone and any number forwarded or transferred to that number.

The cell phone number that I authorize to receive text messages for reminders is:

(_______)__________________________ Carrier: _____________________________

_____ (Client Initials) I consent to **emails** to receive communication as stated above. The email that I authorize to receive an email message for appointment reminders is:

____

It is important to note that email and text communication is not always secure. Messages can be intercepted and for this reason, we do not communicate personal health information through this method.

My signature below indicates that I represent and warrant that I am the person legally responsible for the use of my email and cell phone account, that I am 18 years of age, and that I agree to all terms and conditions of use for the email and text messaging services. I understand that this authorization can only be revoked in writing.

____ _________________________

Client Signature Date

MAIN HELP LINE, 732.774.6886
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Email: info@jfcsmonmouth.org Website: www.jfcsmonmouth.org

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FINANCIAL ACKNOWLEDGEMENT

Jewish Family Children's Services of Monmouth County participates with some insurance plans, please check with a staff member to verify if your plan is one of the ones we are contracted with.

It is your responsibility to know your insurance plan. Most claims are submitted electronically including out-of-network claims. If you are utilizing out-of-network coverage your insurance will reimburse you depending on the coverage of your plan. You are responsible for any charges incurred in this office. For out-of-network members, the payment is due in full at time of service. For participating members, you are responsible for deductibles, copay and/or coinsurance.

Your signature on this document indicates you agree to pay for any outstanding charges incurred in the office. To ensure that claims are processed correctly, please update any changes regarding your insurance company and/or demographics, such as: place of residence, marital status and name change.

Please be aware any outstanding balance remaining on account for 3 months will be sent to collections. Attempts will be made to notify you and arrange payment options prior to sending to collection and you will be responsible for the balance plus collection fees. There will be a $35 fee for any bounced checks and option to repay with a check may not be available to you.

I hereby authorize Jewish Family Children's Services of Monmouth County to provide a copy of and/or disclose information related to my medical records or other information regarding me in your possession, to my insurance carrier(s} or other authorized third-payer(s} and their review organizations, as needed for purposes of determining my benefits for services, for filing a claim for obtaining payment for services and for other purposes as allowed by law.

I knowingly, voluntarily and specifically selected Jewish Family Children's Services of Monmouth County with full knowledge that this provider is out-of-network with my health care plan.

I have read the above office financial policy; I agree and understand the terms.

Client Signature: ____

Date: ____

Quality of
Life for All

Executive Director
Leslie Kornfeld

Director of Operations
Gail Zapata

Clinical Director, Mental Health
Wendy Zagha, LCSW

Clinical Director, Recovery Services
Hilary Krosney-Rediker, LPC, LCADC

Director of Licensing & Holocaust
Survivor Services
Jenifer Zylstra, LSW

Medical Director
Dr. David E. Wolff, M.D., M.P.H.

MENTAL HEALTH FEE AND CANCELLATION POLICY

Jewish Family & Children's Service is a non-sectarian agency serving Monmouth County. Our professional staff is committed to providing respectful, professional psychotherapy services to our clients and to maintaining therapeutic relationships based on open communication, honesty and shared decision making between therapist and client.

Fee Policy:

Our fees are based on a sliding scale which ranges from $60 to $125 per session. The cost for treatment will be determined by the therapist and will be based on your family income.

If you have insurance, you will be required to pay your copay at each session. If you do not have insurance and cannot afford our minimum fee, you will be seen by a MSW student intern.

Cancellation Policy:

If you need to cancel an appointment, you are requested to give at least 24-hours notice. There will be a $60 fee if the cancellation is not given within 24 hours. This fee will be waived in case of an emergency.

If you miss two consecutive appointments, it may be necessary to terminate services. This is our policy for Medicaid clients as well.

This policy is in effect for two very important reasons; first as a non-profit organization we have a significant burden to raise revenue to fund the delivery of valuable human services, some of which are provided for a low fee or no fee basis. Appointments canceled without notice are a lost opportunity to schedule someone else or engage in another activity that will raise needed revenue for our programs; second, we have lists of people who would like to engage in counseling and are waiting for an appointment.

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ACKNOWLEDGEMENT FORM

My signature confirms that I have received a copy of Notice of Privacy Practices, a copy of Patient Rights, and the Client Complaint Procedure.

Legal Name:____ Date of Birth: _______________

Signature: ____ Date: ___________________

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CLIENT RIGHTS

As a client at Jewish Family and Children's Service of Greater Monmouth County, you have a number of rights, which include:

1. The right to be free from unnecessary or excessive medication
2. The right to not be subjected to non-standard treatment or procedures, experimental procedures or research, psycho-surgery, sterilization, electro-convulsive therapy or provider demonstration programs, without written informed consent, after consultation with counsel or interested party of the client's choice.

   If a client has been adjudicated incompetent, authorization for such procedures may be obtained only pursuant to the requirements of N.J.S.A. 30:4-24.2d(3)
3. The right to treatment in the least restrictive setting, free from physical restraints and isolation, provided, however, that a client in Inpatient Care may be restrained or isolated in an emergency pursuant to the provisions of NJ.S.A. 30:4-24
4. The right to. be free from corporal punishment
5. The right to privacy and dignity
6. The right to the least restrictive conditions necessary to achieve the goals of treatment/services
7. The right to confidentiality
8. The right to be informed of services available in the program and names of professional staff responsible for client care
9. The right to be transferred or discharged
10. The right to have access to and obtain a copy of his or her clinical record in accordance with program policies and applicable Federal and State laws.

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NOTICE OF PRIVACY PRACTICES

Revised: 05/07/2018

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INORMATION. PLEASE REVIEW IT CAREFULLY.

If you have questions and would like additional information, you may contact the JFCS Privacy Officer at: 705 Summerfield Avenue, Asbury Park, NJ 07712 (732)774-6886.

WHO WILL FOLLOW THIS NOTICE

This notice describes information about privacy practices followed by all JF&CS employees.

YOUR HEALTH INFORMATION

This notice applies to the information and records we have about your health, health status, and the healthcare and services you receive at this office. We are required by law to give you this notice. It will tell you about the ways in which we may use and disclose health information about you and describes your rights and obligations regarding the use and disclosure of that information. The JF&CS staff will not use or disclose your protected health information except as described in this notice, or otherwise authorized by law.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

The Jewish Family and Children's Service (hereafter JF&CS) provides a broad range of services through a wide variety of health and human service programs. If you receive services from a JF&CS program, our staff may use your protected health information and disclose it to other health and human service programs and outside JF&CS for the following purposes:

We may disclose about you to social workers, psychiatrists, psychologists, office staff and other personnel who are involved in providing these services to you.

For example, information obtained by a social worker or psychiatrist, or member of your health care team will be recorded in your record and used to determine the course of treatment that should work best for you. This information may be shared with other program staff if it is necessary to determine the most appropriate care for you.

For Treatment

Different personnel in our office may share information about you and disclose information to people who do not work in our office in order to coordinate your care, such as coordinating

homecare services. Family members and other healthcare providers may be part of your care outside this office and may require infom1ation about you that we have.

We may tell you about or recommend other treatment options that may be of interest to you.We may tell you about related programs or services that may be of interest to you.

For Payment: A bill may be sent to you or any private or public source of health coverage you have identified. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, treatment, and services provided. We may also tell your health plan about a treatment you are going to receive to obtai11. prior approval, or to determine whether your plan will cover the treatment.

For Healthcare Operations: We may use and disclose health info1mation about you in order to run the office and make sure that you and our other clients receive quality care. For example, members of a quality assurance team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

We may contact you by mail or telephone if we need to reach you, for example to confirm or change an appointment.

Please notify us in writing (at the address listed at the top of the Notice) if you do not wish to be contacted at a particular telephone number or address. JF&CS will accommodate reasonable requests to communicate health information by alternative means or at an alternative address.

SPECIAL SITUATIONS

We may use or disclose health information about you without your permission for the following purposes, subject to all applicable legal requirements and situations:

To Avert a Serious Threat to Health or Safety. We may use and disclose health infonnation about you when necessary to prevent a serious threat to your health and safety of the public or another person.

Required By Law. We will disclose health information about you when required to do so by federal, state or local law.

Health Oversight Activities. We may disclose health information to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the healthcare system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. Subject to all applicable legal requirements, we may also disclose health information about you in response to a subpoena.

Law Enforcement We may release health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process, subject to all

applicable legal requirements.

<u>Coroners, Medical Examiners</u> With the possible exception of certain information concerning mental health disorders and/or treatment, drug & alcohol abuse and/or treatment, and/or HIV status (for which we may need your specific authorization or a court order), we are also permitted to provide some health information to the coroner or a funeral director, if necessary, after a client's death, and/or to the appropriate organ procurement organization, if the client wished to make an eye, organ or tissue donation after their death.

<u>Business Associates.</u> Our contracts with our Electronic Health Record and other programs required for the coordination of business operations and services for the agency and your treatment are HIPPA compliant to ensures your privacy.

OTHER USES AND DISCLOSURES OF HEALTH INFORMATION

We will not use or disclose your health information for any purpose other than those identified in the previous sections without your specific, written *Authorization.* We must obtain your *Authorization* separate from any *Consent* we may have obtained from you. If you give us *Authorization* to use or disclose health information about you, you may revoke that *Authorization,* in writing, at any time. If you revoke your *Authorization,* we will no longer use or disclose information about you for the reasons covered by your written *Authorization,* but we cannot take back any uses or disclosures already made with your permission.

If we have HIV, STD's, TB, substance abuse, mental health, or genetic information about you, we cannot release that information without a specific authorization from you. In order to disclose these types of information for purposes of treatment, payment or healthcare operations, we will have to have your signed *Authorization* which complies with the law governing these records.

<u>YOUR RIGHTS REGARDING PROTECTED HEALTH INFORMATION ABOUT YOU</u>

You have the following rights regarding protected health information we maintain about you.

<u>Right to Inspect and Copy.</u> You have the right to inspect and copy your health information, such as counseling, social work and billing records, that we use to make decisions about your care. You must submit a written request to the Privacy Officer contact listed at the top of the Notice in order to inspect and/or copy your health information. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other associated supplies, as allowed by New Jersey state law. We may deny your request to inspect and/or copy in certain limited circumstances. If we deny your request, we will tell you, in writing, our reasons for the denial. If you are denied access to your health information, you may ask that the denial be reviewed. If such a review is required by law, we will select a licensed healthcare professional to review your request and our denial. The person conducting the review will not be the person who denied your request, and we will comply with the outcome of the review.

Right To Request Amendment. If you believe health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment as long as the information is kept by this office. To request an amendment, complete and submit a Medical Record Amendment/Correction Fonn to the Privacy Officer contact listed at the top of this Notice. We may deny your request for an amendment ifit is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

(a) We did not create, unless the person or entity that created the information is no longer available to make the amendment.

(b) Is not part of the health information that we keep

(c) You would not be permitted to inspect and copy.

(d) Is accurate and complete.

Our written denial will state the reasons that your request was denied and explain your right to file a statement of disagreement with us. If you do not wish to do so, you may ask that we include a copy of your request form, and our denial form, with all future disclosures of that health information. We may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures". This is a list of the disclosures we made of health information about you for purposes other than treatment, payment and healthcare operations. To obtain this list, you must submit your request in writing to the Privacy Officer contact listed at the top of the Notice. It must state a time period, which may not be longer than six (6) years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper or electronically). We may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or healthcare operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for it, like a family member or friend.

We are Not Required to Agree to Your Request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

To request restrictions, you may complete and submit the Request for Restriction on Use/Disclosure of Health Information to the Privacy Officer contact listed at the top of the Notice.

Quality of Life for All

Jewish Family and Children's Service of Monmouth County
705 Summerfield Avenue, Asbury Park, NJ 07712 • Phone: (732) 774-6886

Client Complaint Procedure

Revised: 07-2022

1.1 Policy

Clients have the right to express complaints and have the complaints considered in a complaint process which assures the client a serious consideration of their concerns. This includes alleged cases of physical, sexual, verbal, or psychological abuse--staff person to consumer.

1.2 Procedures

A. Complaint and Review Procedure:

This policy shall apply to any question (s) related to service delivery, denial or termination of services. It will apply to all client applicants to the agency who have been clients within the last three months or his/her designee, parent or guardian.

I. Explanation of Complaint and Review Procedure to Clients:

a. Each client will be made aware of this complaint review process at the time of the intake and at the time a complaint is filed.

b. A written copy of the complaint and review procedures shall be made available to clients during the intake process.

c. Clients not accepted for service shall be informed of the process for grievance filing, as well as potential remedies.

d. A list of known external advocacy services, which are available to clients, will be stated in this policy and procedures.

II. Posting of Policy:

A statement denoting the availability of the above mentioned policies will be posted in the waiting room at each of the Agency's three offices.

B. Designation of a Jewish Family and Children's Service Ombudsperson to Receive Complaints:

1. The Jewish Family and Children's Service Director of Professional Services is designated as the agency Ombudsperson. His/her responsibilities are:

   a. To receive complaints either in writing or in person.

b. To facilitate the resolution process within the agency for clients who make complaints.
c. To act as an advocate for clients who are making complaints.

2. A client's complaint will be forwarded to the agency's Director of Professional Services who will offer a meeting with the client within one week of the complaint.

    a. The Director of Professional Services will submit a written report of findings, resolutions and/or recommendations to the client and Executive Director within seven working days of this complaint.
        i. A copy of this report will be maintained by the agency.

    b. If a complaint has been resolved to the client's satisfaction, the grievance process will end at this juncture. If it has not, the additional procedures described below will be implemented.

3. At the time a client is admitted into treatment, he/she will be given a copy of Consumer Rights and Client Complaint Procedures. The client will then sign at the bottom of the HIPAAA/Disclosure of PHI Form stating that he/she has received a written copy of the Client Complaint Procedure and Consumer Rights, and that the client understands both documents.

Further Internal Agency Complaint Resolution

1. The agency will permit and encourage clients who object to the decision of the therapist or ombudsperson to consult with and obtain the opinion of a second person either within or outside the agency.

2. If the complaint has not been resolved by the agency ombudsperson to the client's satisfaction, the client may request either in writing, in person, or by phone, that the agency's Executive Director review the findings.

3. The agency executive Director will respond to this request within seven working days.

4. If the complaint has not been resolved to the client's satisfaction, the client may request review by the Jewish Family and Children's Service Board of Directors. This appeal will be directed to the agency's Executive Committee for a response. That committee shall respond in writing within ten working days of the application.

5. The Board of Directors Executive Committee decision is the final internal appeal option for a complaint.

1.3 Confidentiality

A client who requests a review of the complaint by the agency Ombudsperson, Executive Director, and Board of Directors will be required to consent to the disclosure of records in order to authorize persons reviewing the matter to discuss the subject of the complaint with relevant agency staff if necessary.

1. If the client does not sign an appropriate release form, his/her name can be deleted or disguised in relevant materials.

1.4 External Advocacy Services Available to Agency Clients

Clients do not have to utilize the internal grievance process prior to going to the following outside agencies. Clients participating in agency programs may avail themselves of the following external resources at any time during their treatment.

COMMUNITY MENTAL HEALTH LAW PROJECT OFFICE AND ADMINISTRATION
601 Grand Avenue
Asbury Park, NJ 07712
Phone No: (732) 502-0059

MONMOUTH COUNTY MENTAL HEAL TH ADMINISTRATOR
Monmouth County Division of Mental Health
P.O. Box 3000
Freehold, NJ 07728-1255
Phone No: (732)431-7200
Fax No. (732)308-3700

DIVISION OF MENTAL HEAL TH ADVOCACY
Justice Hughes Complex
25 Market Street
Trenton, NJ 08623
Phone No: (877) 285-2844

DISABLITY RIGHTS NEW JERSEY
210 South Broad Street 3rd Floor Trenton, NJ 08608
Phone No: (1-800)927-7223

DIVISION OF CHILD PROTECTION AND PERMANANCY
20 West State Street, 4th Floor
PO Box 729
Trenton, NJ 08625
Child Abuse/Neglect Hotline
Phone No. (1-877-652-2873

ADULT PROTECTIVE SERVICES
Family and Children's Services of Monmouth County
191 Bath Avenue
Long Branch, NJ 07740
Phone No. (732)-531-9191
Fax No. (732)-897-9651

DIVISION OF MENTAL HEAL TH SERVICES UMBUDS PERSON
Susan Mills
P.O. Box 362
Hamilton, NJ 08625
(609)984-4813